SELF IN RELATIONSHIP
IN WOMEN WHO ENGAGE IN DISORDERED EATING

BY

ROMY LANIER CAWOOD

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By

Romy Lanier Cawood

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Chairperson: Martin Heesacker, Ph.D.
Major Department: Psychology

This study examined the relationships between sense of self and disordered eating, and self-silencing in romantic relationships and disordered eating. The study focused on disordered eating as a continuum, encompassing the clinical and subclinical areas as experienced by women of college age. Participants were drawn from psychology classes, and responded to a questionnaire comprised of measures to assess identity development, self-silencing, and level of disordered eating. Support was found for the prediction that women who were in a state of flux with regard to their identity show higher levels of disordered eating. Support was also found for the prediction that women who engage in higher levels of self-silencing in romantic relationship show higher levels of disordered eating.

Whereas data were consistent with a conceptualization of disordered eating as a continuum, results revealed that only one of the two measures of disordered eating was effective at assessing level of disordered eating along such a continuum. Participants categorized as being in a more well-defined identity status engaged in lower levels of self-silencing in romantic relationships than did participants in a less well-defined identity status. There was no significant interaction between identity status and self-silencing in romantic relationships on disordered eating. A substantial majority of participants reported a desire to lose weight, a fear of weight gain, and that their weight and/or body shape influenced how they felt about themselves. Relationships between self-relevant factors and disordered eating were not detected through use of a binary measure distinguishing participants who were or were not diagnosable with an eating disorder, but were detected through use of a measure that captured the continuum of disordered eating.

CHAPTER 1

INTRODUCTION

Inquiry into the field of disordered eating continues to evolve, branching into different areas of focus, including the cognitive, social, behavioral, biochemical, cultural, self, and interpersonal areas (Fallon, Katzman, & Wooley, 1994; Halmi, 1992; Szmukler, Dare, & Treasure, 1995). There is substantial overlap among elements of the various perspectives, rather than well-defined, rival theoretical camps, although the field is not free of disagreement. To isolate a particular element for the purposes of research is difficult, even if useful.

The field has a history now, extending into the last century and beyond (Blumberg, 1988; Seid, 1994; Silverman, 1992), though changing cultural understanding of illness and wellness makes the task of delineating the continuity difficult (Perlick & Silverstein, 1994). The weaving of history into the current increasing incidence of disordered eating (Seid, 1994), in order to identify a straightforward explanation and an equally straightforward treatment plan, has yet to prove successful. The topic is anything but straightforward, a fact unfortunate for scientists and

practitioners who welcome and indeed prefer, order and clarity.

There are several key issues around which most recent dialogue centers: First, to what extent is disordered eating culture-bound in the manner that has been traditionally advanced (particular to White, middle-to-upper class young women)?; Second, how well has research addressed patterns characterizing groups of various racial and ethnic backgrounds, social classes, ages, and sexual orientations (Thompson, 1994, 1996; Vandereycken & Hoek, 1992)? A third key issue concerns the etiological role of sexual abuse in the development of disordered eating (Dare & Crowther, 1995; Root, 1991; Wooley, 1994). Finally, the feminist sociocultural current of thought is gaining momentum, drawing strength from a collaboration of theorists across disciplines within and beyond the broader area of psychology (Brown, 1985; Chernin, 1985; Steiner-Adair, 1989, 1990, 1991a, 1991b, 1994; Wooley, 1991, 1994a, 1994b; Wurman, 1989).

Taking the perspective of this latter current, this study examines view of self in women who engage in eating disordered behaviors. My interest in self-view stems from my broader interest in the self-in-relationship. The methodology of my approach reflects this broader interest, incorporating assessment of women's view of self, and their views of self's place in a relationship context.

I have used the term "disordered eating" to refer to a broader range of behaviors than those typically denoted by the term "eating disorders," the latter term generally implying eating difficulties that are clinically diagnosable, such as anorexia nervosa or bulimia nervosa. Disordered eating, on the other hand, may range from the more minor, such as periodic preoccupation with thoughts of food, to serious physiological and psychological distress. I also use the terms "clinical," "subclinical," and "subthreshold" in reference to degree of disordered eating. The term "clinical" denotes disorder or distress at a clinically diagnosable level; that is, the disorder meets formal DSM-IV (1994) criteria for a specific diagnosis. "Subclinical" (or "subthreshold") indicates the presence of features of the disorder, but not with the intensity, severity, or duration required for a diagnosis.

In choosing to focus on the "self," I am indebted to a large group of theorists who have considered and explored the ways in which the self plays a role in disordered eating (Barth, 1989; Bruch, 1962, 1973, 1978, 1982; Casper, 1992; Dare & Crowther, 1995; Frederick & Grow, 1996; Geist, 1989; Sands, 1989, 1991; Schupak-Neuberg & Nemeroff, 1993). There are those who take a more intrapsychic viewpoint, including one that stems from a classical self-psychological approach (Bruch, 1962, 1973, 1978, 1982; Geist, 1989; Sands, 1989, 1991). There are also those who study the self within a

relational (Steiner-Adair, 1989, 1991a, 1991b) and a broader sociopolitical framework (Brown, 1985, 1989; Chernin, 1985, Steiner-Adair, 1991), these latter theorists working more often from a feminist standpoint.

Theorists and clinicians whose orientation stems from, or is closely tied to psychodynamic or classical self-psychological perspectives suggest that women with eating disorders are lacking, or struggling to define a clear sense of self (Bruch, 1962, 1973, 1978; Geist, 1989; Sands, 1989, 1991). They also have hypothesized a disturbance in the parent-child relationship. In this relationship, the flow of empathy, in particular the reflection and nurturance of the child's sense of self, has been jeopardized. Other writers acknowledge the deficits in self-structure, but concern themselves more with the influences of cognitive factors (Casper, 1992), sociocultural ideals (Dare & Crowther, 1995), and developmental/cultural demands (Barth, 1989). Experimental work (Frederick & Grow, 1996; Schupak-Neuberg & Nemeroff, 1993) has explored the manifestations of these intrapsychic dynamics as they figure into the eating disorders.

Other theorists have structured their hypotheses regarding disordered eating around the self in relationship, and the self in the broader culture. Steiner-Adair (1989, 1991a, 1991b) explored a framework that defines women's identity development as one in which relationships are

important in a way that is different from the experience of men. She has argued that confusion results as women strive to negotiate both their relationship-oriented development and the cultural dictates regarding relationship, as well as cultural dictates regarding the female body. Tolman and Debold (1994) described the ways in which social forces converge so as to encourage women's alienation from their own bodies.

Experimental study has also addressed the romantic relationships of women with eating disorders, including satisfaction in relationships with men and women (Thelen, Farmer, McLaughlin, Mann, & Pruitt, 1990; Thelen, Kanakis, Farmer, & Pruitt, 1993); quality of relationships, social skills and perceived social support (Grissett & Norvell, 1992); conflict resolution skills in the marital relationship (Van Buren & Williamson, 1988); and psychological distress in husbands of women with eating disorders (Van den Broucke, Vendereycken, & Vertommen, 1994).

Placing disordered eating within the broad sociocultural context, some theorists have attributed a causal role to Western culture's primary valuing of "masculine" ways of being and relating (Brown, 1985, 1989; Chernin, 1985; Steiner-Adair, 1991), and to gender discrimination (Perlick & Silverstein, 1994; Wolf, 1994). Theorists have also examined the ways in which culturally-

dictated assignment of gender-related roles in romantic relationships affects women's experience of self (Jack, 1991; Jack & Dill, 1992). They have found that women's internalization of these roles can lead to a subordination or "loss" of self in the relationship context, as well as to depression.

In general, feminist viewpoints emphasize the importance of social roles, the relationship between gender and power, and the individual's perception of self and other in this context. These viewpoints stress the constructive aspects of coping efforts that may drive the disordered eating (which have clearly gone awry), and highlight society's part in this clinical picture. These theorists take the perspective of the women who struggle with disordered eating, and emphasize the challenge facing them as they strive to evolve a sense of who they are and how they fit into the larger society.

A shared feature of the viewpoints just described is their acknowledgement of the importance of a developmental focus. This idea is consonant with research emphasizing the relevance of the developmental task of defining the self (Belenky, Clinchy, Goldberger, & Tarule, 1986; Brown, 1989; Erikson, 1968; Gilligan, 1982, 1990; Josselson, 1987; Marcia, 1966, 1983, 1987) during adolescence and the years of early adulthood. The high rates of prevalence of eating-disordered behaviors found among college-aged women (Mintz &

Betz, 1988) also support the viability of a developmentally-grounded framework.

It has also been suggested that Western cultural valuing (or devaluing) of theoretically "masculine" and "feminine" qualities profoundly affects the identity development process (Chernin, 1985; Steiner-Adair, 1989, 1991a, 1991b; Wooley, 1991, 1994a, 1994b). Integrating perceptions of cultural valuing of these qualities with one's own values and perceived self-relevant qualities becomes the task requisite to negotiating a healthy sense of self. When these values conflict, or more specifically, when a woman perceives that much of what is important to her is not equally valued by society, the situation may be conducive to disordered eating. The link between these perceptions and disordered eating may take various forms, for example: dietary restriction for the sole purpose of attaining the culturally-valued, thin ideal; the realm of food and eating as the only perceived viable outlet for distress, or the only area within personal control.

The assumption pivotal in this work is that a secure sense of identity, experienced individually, and in the context of relationships, is a buffer against psychological distress. Marcia (1966, 1987, 1989) developed Erikson's (1959) theory of identity development over the life span. He focused on the period of adolescence, and formulated a classification system that provides the basis for

quantitative assessment of identity development status or process. Marcia has suggested, at a basic level, that having a developed identity "usually makes a positive difference in how one feels about oneself" (1987, p. 165). Marcia's work is grounded in the idea that identity development mediates such intrapsychic and interpersonal variables as: experiencing of anxiety (Marcia, 1966, p. 552), performance under stress, vulnerability of self-esteem (Marcia, 1966, p. 557), capacity for intimate relationships (Marcia, 1987, p. 163), and vulnerability to a range of types of pathology (Marcia, 1987, p. 168).

In the interpersonal area, there is evidence to support the connection between subordination, or loss of self in the context of romantic relationships and psychologial distress in the form of depression in women (Drew & Heesacker, 1997; Jack, 1991; Jack & Dill, 1992). Jack's (1991) original work was based on interviews with clinically-depressed women. She explored their cognitive schemas regarding intimate relationships. Her model suggests that culturally-derived attitudes and beliefs about women's place in intimate relationships can lead to a silencing of specific thoughts, actions, and feelings, associated with a healthy self:

> The self-silencing contributes to a fall in self-esteem and feelings of a "loss of self" as a woman experiences, over time, the self-negation required to bring herself into line with schemas directing feminine social behavior. (Jack & Dill, 1992, p. 98)

Specific relationships and social situations can then "interact with a woman's own endorsement of these schemas to affect her vulnerability to depression" (Jack & Dill, 1992, p. 99). Drew and Heesacker (1997) studied three models: the first posited an association between self-loss and depression, the second an association between relationship loss and depression, and the third, an interaction between self and relationship loss and depression. They found strong support for the self-loss and depression relationship, and no support for the other models.

Understanding the connections between the various facets of human functioning implicated in disordered eating is relevant on two levels: the clinical level, in which healing is attempted; and the sociopolitical level, in which wisdom through increased awareness has the power to alter construal of the very deepest meanings of human relationship that nourish and connect people to one another.

I have proposed this exploration assuming a developmental backdrop, against which women must navigate the sociocultural terrain of gender. This dissertation evaluates two ideas: first, the idea that difficulty in negotiating the normal developmental process of defining a sense of self increases women's vulnerability to disordered eating; and second, the idea that adherence to beliefs consonant with subordination of self in romantic relationships increases women's vulnerability to disordered

eating. In other words, a muffled or unarticulated sense of self, whether experienced individually, or in the context of a romantic relationship, leaves a woman more vulnerable to psychological distress in the form of disordered eating, according to this perspective. In this study, I do not suggest that an unarticulated sense of self and self-silencing are uniquely associated with disordered eating to the exclusion of other forms of psychological distress. Rather, the focus of this study centers on disordered eating as a particular psychological experience.

Hypotheses

(1) Participants in stages of less defined self-identity development will have significantly higher scores on the two measures of disordered eating than will participants in stages of more defined self-identity development.

(2) Scores on a measure of subordination of self in romantic relationships will be significantly and positively correlated with scores on two measures of disordered eating.

CHAPTER 2

REVIEW OF THE LITERATURE

This review of literature centers around the concept of the self and its relationship to disordered eating. The overall organization is a continuum, beginning with theory of a more intrapsychic focus, extending toward theory based on a more environmental, sociocultural viewpoint. Within this continuum, I have created an organization in three parts: the self, the self in relationship, and the self in sociocultural context. These areas are conceptually broad, and I have endeavored to address each in a way that relates the variety of perspectives that have informed my thought. I should also note that it is difficult to consider these areas separate from one another. I acknowledge the element of artificiality inherent in this organization, and have chosen it only because of the clarification I believe it provides. Some of the work I will mention could fit into different places in this review, in which cases the ultimate location choice is arbitrary. In my view, the overlap between areas is natural and serves as a bridge between the areas.

The parameters of this literature review are defined by the intersection of the areas of self in relationship and

eating disorders. Various combinations of the following key words or phrases were used: romantic relationship, relationship style, attachment style, interpersonal, eating disorder, disordered eating, anorexia, and bulimia. In exploring the areas of relationship and self, the search was contained by the broader area of disordered eating. Selected work that buttressed this core area was also included.

The Self

Discussion of the self figures into discussions of disordered eating on different levels and in different ways. I will begin with Hilde Bruch, a clinician and writer of psychodynamic orientation, who did much to pioneer understanding of the eating disorders, sketching and then elaborating the connection between eating disorders, the self, and the interpersonal (1962, 1973, 1978, 1982). Much of her thought is based on work with women with anorexia. She noted a common theme among her patients: a lack of conviction of the inner "substance and value" of the self, combined with a preoccupation with meeting the expectations of others, which become self-defining (1978). Specifically, the qualities she described include oversubmissiveness, along with a lack of autonomy, clear opinions, and judgments. The overall dynamic, however, structures both friendships and family relationships. The women with whom she worked experienced difficulty in distinguishing their

own sense of self, and turned to others as a guiding mirror. Bruch quotes one of her patients:

> I was sitting with these three people but I felt a terrible fragmentation of myself. There wasn't a person inside at all. I tried with whoever I was with to reflect the image they had of me, to do what they expected me to do. There were three different people, I had to be a different person to each, and I had to balance that. It was the same when I was a child and had friends. It was always in response to what they wanted. (1978, p. 49)

Bruch hypothesized the influence of various factors in the etiology of eating disorders: the cultural emphasis on slimness as beautiful, parenting in which the individuality and autonomy of the child were either not recognized, or not nurtured, and the experience of social demands as overwhelming to young women.

Bruch focused particularly on the parent-child relationship, in which the child's needs are not appropriately encouraged, acknowledged, and reinforced, resulting in the child's feelings of confusion, helplessness, and ineffectiveness. Deficits in self-awareness would also result, leading to development of an eating disorder. Within this framework, the discipline and control over eating and the body serve to compensate for an absence of the experience of inner self structure (Bruch, 1962, 1973, cited in Casper, 1992, p. 291).

> Betty explained that losing weight was giving her power, that each pound lost was like a treasure that added to her power. This accumulation of

> power was giving her another kind of "weight," the right to be recognized as an individual ... (p. 4)

In this way, control of eating allows these women to feel that there is a "core to their personality" (1978, p. 4).

Taking a self-psychological perspective, Geist (1989) suggested an understanding of the eating disorders as a "major form of self pathology in which there has been both a 'traumatic' and chronic disturbance in the empathic connectedness between parent and child" (p. 5). Geist used the term "trauma" to indicate a "massive failure" (p. 5) entailing disruption of the empathic bond between parent and child, and not to denote a distinct memorable event. The disrupted empathy, typically occurring during the ages of 18-36 months, prevents the internalization of self-soothing and tension-modulating abilities. When a child's subjective experiencing of the world is correctly understood and confirmed, the child "experiences a number of important self-enhancing consequences that reverberate, however disparately, throughout each state of development" (p. 8). With the trauma of empathic failure, however, there may be a complete collapse of these self-object functions, leaving the child to otherwise sustain the self's integrity.

The stage is set for the evolution of an eating disorder. In his young female patients with eating disorders, Geist perceived the emptiness of a "depleted and dying self," and a loss of the capacity to comprehend what

they are experiencing and to integrate it into an aspect of a more completely experiencing self" (p. 13). As a result of the absence of empathic parental responsiveness, the young woman is left without a context for experiencing her feelings of emptiness, and so emptiness is split off, or dissociated. In a dissociated state, food and the eating functions are experienced with a sense of artificiality and distance. Food

> can be accepted as medicine, or eating habits can be altered through various short-term behavioral manipulations, but the creative enjoyment of food can never become a pleasurable integrated, unself-conscious function. For the split-off emptiness must be reexperienced and reintegrated into a more consolidated self before true filling up is possible. (p. 15)

Geist asserted that disordered eating behaviors be viewed as healthy efforts to "shore up the self in the face of selfobject failure" (p. 17), and that early selfobject needs must be reactivated in order for healing to occur.

Also grounded in a self-psychology viewpoint, Sands (1991) stated that eating disorders result from "chronic disturbance in the empathic interplay between the growing child and the caregiving environment" (p. 35). Because of this disturbance, the child's needs and feelings are repressed or split off from the self-structure, leading to structural impairment in the capacity for self-cohesion and the regulation of self-esteem. The individual develops

another system in order to meet self-object needs, in which food replaces people.

Sands suggested that women are more vulnerable to the eating disorders than are men because of several factors, including cultural preoccupation with the female body, family emphasis on the importance of physical appearance, problems to which the mother-daughter relationship is vulnerable, and the scarcity of "idealizable female figures" (Sands, 1989). Sands (1991) argued that in bulimia, an entire set of feelings, needs, and perceptions are dissociated from the rest of the individual's self experience, into a separate self, which she terms "the bulimic self." In order for healing to occur, the therapist must seek out and empathize with this bulimic self, acknowledging its needs.

Dare and Crowther (1995) sketched an "integrated" object-relations model of eating disorders, in which women with eating disorders "display an intense and characteristic difficulty in believing in the integrity of their selves." These authors suggested that etiology is dual--internal and external. The "external" refers to cultural ideals of body type. The "internal" is not purely intrapsychically isolated, but may refer to internalized cultural ideals, in other words, the external internalized. There are culturally ideal body types for both women and men, certainly. However, the authors pointed out that there are

> societal pressures on women which emphasize that they should be concerned with social judgments about their appearance more than on their more general personal characteristics. The different pressures on men and women as to the nature and importance of ideals of adult shape become a part of the internal world. By some process operating from the beginnings of social life, personal psychology is shaped by these patriarchal structures along gender differentiated lines. (p. 134)

The sociocultural influences not only the physical self, but also the interpersonal self. Psychodynamic theorists suggest that the social roles awaiting adult women contribute to the development of eating disorders in young women. Specifically,

> ... the girl soon knows that the woman she is going to become will be strongly expected to put the needs of the other, the object of her interests and loves, especially if they are male, before the needs of her subject, her self ... This aspect of self-organization, the placing of the self under the orders of the other, seems to be experienced by the person destined to develop an eating disorder in a particular way ... (Dare & Crowther, 1995,p. 135)

In this way, the eating disorder can be viewed as a way of asserting individuality. At a time when a young woman is unsure of her own identity, and feels pressured to <u>be</u> in a way that is defined by others, the eating disorder is part of a mode of defiance. The defiance becomes a form of assertion of self.

Casper (1992) viewed anorexia nervosa as a "reorganization of the self through domination of the body" (p. 296). Fixed cognitions contribute to the generation of a new constellation of values and goals. These values are

characterized by "prohibitions that become fully integrated into the patient's intrapsychic processes and therefore cannot be lifted at will" (p. 297). A woman with anorexia invests in her body as a representation of the self. Increasing investment is accompanied by increased detachment from relationships, including those with family and friends. Other influencing factors are such personality characteristics as a tendency toward self-discipline, and a tendency toward "categoric uncompromising thinking" (p. 297). A woman discovers that controlling, and then losing weight is a way to feel better, and the weight loss becomes a strong reinforcer. The body becomes split into parts--good and bad. Bad, or rejected parts of the body are identified with facets of the self that are deemed unacceptable, such as low self-esteem and a fear of "being nobody."

Barth (1989) viewed bulimia in particular as a coping mechanism that serves to aid women (albeit to their detriment) in their struggle to develop "self-structures" and to resolve conflicts surrounding separation and individuation. She has pointed out that going to college is a demanding transition during which many women develop bulimia, and that the eating disorder

> often helps young women cope with intolerable inner experiences related to the emotional tasks of separating from family, developing a sense of identity, and finding the capacity to be both separate from and connected to others. (p. 137)

Barth has noted the challenge for many of these women of integrating their femininity with traditionally masculine traits, now very valued in this society. Integrating these characteristics into the self becomes crucial to women's transitions to adulthood.

Similar in many ways to the perspectives just described, Wurman (1989) has looked to the social requirements for femininity and the ways in which they hinder a young woman's developmental experience and make her vulnerable to the eating disorders. Specifically, she has implicated:

> ... overvaluing of appearance; the creation of an alienated sense of body self; and the emphasis on the development of personal qualities which facilitate defensive relatedness and inhibit the development of a sense of agency. (p. 175)

Many young women acquire a sense of the woman they are supposed to become as someone who is independent in the sense of not needing anyone, and who is beautiful according to narrow standards (and by implication, beautiful from the outside looking in, not from the inside looking out). According to Wurman, efforts to assimilate these values can lead to the eating disorders. In anorexia, women are often struggling "for power and personal effectiveness, for a sense of value and accomplishment" (p. 175). In contrast, the woman with bulimia is more in touch with her emotional needs, and also tends to split off her "bad self" into the bulimic behavior (a formulation articulated by Sands, 1991,

discussed earlier). Women with anorexia and bulimia share an exaggerated view of the importance of thinness, and a need to present the self as perfect to the world. For example, Wurman quotes a young woman: "It's like a sheet of glass between me and the world. If I look perfect, then nothing can touch me; no one can hurt me" (p. 177).

Schupak-Neuberg and Nemeroff (1993) advance a "metaphorical perspective" of "body as self," as an approach to understanding bulimia. This perspective hypothesizes that women with bulimia do not have a clear and defined sense of self. The physical body becomes a way to define and regulate the self. In search of support for this model, the authors investigated several areas of experience, including "identity disturbance" and the "use of the binge and purge as means of emotional regulation" (p. 335).

They found that women with bulimia exhibited a greater degree of identity confusion, and instability of self-concept than did a normal control group and a group of individuals who engaged in binge eating. In addition, for women with bulimia, the binge was associated with an escape from self-awareness, and the purge was used to manage negative affect. Schupak-Neuberg and Nemeroff (1993) suggested that women with bulimia desire the establishment of an "independent sense of self" (p. 344). They also cautioned that the evidence garnered in support of their

model did not constitute direct assessment of the self-body equation.

In their model of eating disordered behaviors and attitudes, Frederick and Grow (1996) looked to the interacting factors of self-esteem and autonomy. Specifically, they posited a mediational model, in which a sense of autonomy contributes to global self-esteem, such that self-esteem is the mediating variable between autonomy and eating disordered attitudes and behaviors.

In their study, Frederick and Grow chose three measures to assess each of the three constructs that form their hypothesis: the General Causality Orientation Scales (autonomy), the Eating Disorders Inventory (eating disordered attitudes and behaviors) and the Multi-Dimensional Self-Esteem Inventory (self-esteem). Through path analysis, they were able to gain support for their hypothesis; that self-esteem mediates the relationship between autonomy and eating disordered attitudes and behaviors. The authors were careful to limit discussion of their model to women from Western cultures. They suggested that for these women there is a basic need for autonomy:

> When women experience a lack of autonomy and self-determination, they are likely to fail to develop global self-esteem. As a result, women in Western cultures may increase their risk of developing an eating disorder as a means of regaining some sense of control and self-worth. (p. 225)

The Self in Relationship

Steiner-Adair (1989, 1991a, 1991b) has viewed women with eating disorders as individuals who "corporally express their emotional starvation and their difficulty in digesting interpersonal nourishment" (p. 225). She has highlighted the importance of a social context that features "debilitating sex-role stereotypes and androcentric cultural norms, which unrealistically idealize nurturing and actually promote individualism and autonomy" (p. 226). Steiner-Adair has cited research (Brown, 1989) indicating that as girls mature, and particularly around the ages of 11 and 12, they begin to become aware of the cultural idealization of relationships, in which women's value resides in their ability to be simultaneously "all-caring" and "independent." These girls then doubt their previous knowledge and beliefs about relationships, and withdraw in their effort to understand the apparent discrepancy (Gilligan, 1990, cited in Steiner-Adair, 1991). Confidence is lost in this

> struggle with androcentric cultural norms, which present an unreal view of (1) females as all-caring; (2) relationships as all-inclusive; and (3) adulthood as a kind of individualism, autonomy, and independence that does not include interdependence. It is also at this point that girls begin to wish for the "perfect relationship" in which no one gets hurt, and try to be the perfect girl ... (Steiner-Adair, 1991, p. 228)

Steiner-Adair has situated both anorexia and bulimia in a relationship framework. She has suggested that women with anorexia harbor a deep "starvation" (p. 230) for closeness,

though they may appear to completely lack relatedness. She also has stated that these women fear connection in so far as it represents a loss of a "separate sense of self":

> At worst, they fear that to connect is to lose oneself in a malevolent, overwhelming presence --and to admit a need for connection is to put themselves at jeopardy in an annihilating, dependent position--from which to separate is to destroy self and others and incur great wrath. (p. 231)

According to Steiner-Adair (1991) the therapeutic task regards an integration of connection. In contrast, work with women with bulimia involves differentiation. These women "struggle with connection in fear of separation and they struggle with separation in fear of fragmentation and abandonment" (p. 231). The eating disorder, in whatever form, may be viewed as the woman's way of speaking in a world in which she perceives that she does not have a voice. The eating disorders are centered in the dynamics of sense of self and connection and disconnection in relationships. Steiner-Adair has suggested that a current underlying disordered eating is the cultural climate in which "the relational component of female identity development" (1989, p. 154) is not supported, and so women's efforts to mature into adulthood within the relationship context is itself jeopardized.

Tolman and Debold (1994) highlighted the relationship Western culture has created between body and self-image, as well as the way male-female relationships figure into the

etiology of disordered eating. They suggested that various cultural forces--unrealistic, uniform and pervasive images of female beauty and social and political objectification of women--converge into women's alienation from their own physical and emotional experiencing. That is, the cultural climate becomes conducive to a disconnection in the sense of self.

The authors interviewed two groups of girls as part of the Harvard Project on the Psychology of Women and the Development of Girls. The first group included girls ranging in age from 6 to 17 years, from a private girls' school located in Cleveland, Ohio. The second group was comprised of girls in grades 8 to 10, economically disadvantaged, and considered to be at risk for school dropout and early pregnancy. The research format was a semistructured clinical interview, during which the girls were asked about "experiences with conflict and with various relationships in their lives" (p. 303).

> Among the themes that emerged, is that of body representing self. Said one seventh-grader: It's just that I don't like being -- I don't like to sound that I think good of myself, 'cause I really don't. I don't see how people, like, they say, "Oh [you have] such a good personality and [are] so nice." And I'm like, "No, look at my nose, look at my legs, no." (p. 305)

When the interviewer later asked this same young woman what would make her happy, she replied "being skinny" (p. 305).

The separation between self as perceived by other girls and other boys also was apparent. For example, those attending the private girls' school were aware of how their behavior was affected by the sex of the observer:

> It would be a lot different if there were [boys at the school] because with the boys, we would--we wouldn't be ourselves at all, we wouldn't come to school without looking as good as we can. And here we just come to school and no one cares what anyone else looks like. (p. 305)

The authors suggested that not only is outward behavior affected, but more deeply, so are the inner perceptions and experiences of the self: "Living as images with their feelings flattened and appetites unknown, they are at psychological risk" (p. 312).

Quantitative study of the eating disorders and relationships has been approached from various angles. Satisfaction in relationships with men of women with bulimia was examined in a series of longitudinal studies (Thelen, Farmer, McLaughlin Mann, & Pruitt, 1990; Thelen, Kanakis, Farmer, & Pruitt, 1993). Female participants were administered the Bulimia Test (Smith & Thelen, 1984), and were classified according to cutoff scores into three categories, including the bulimic range, the subclinical range, and the normal range. Degree of bulimic behavior was correlated with satisfaction with interpersonal relationships (with males and with females) over time.

In the first study (Thelen et al., 1990), spanning a 19-month period, women in the subclinical range showed the most substantial reduction in eating disordered symptomatology, as well as the greatest improvement in their ratings of interpersonal relationships with men. In contrast, no significant correlations were found between scores on the Bulimia Test and ratings of satisfaction in interpersonal relationships with women. The second study was an extension of the first, in which the same measures were administered. The 19-month period from the first study was extended to a 31-month period in the second study. There were no significant changes in any of the correlations from the first to the second study.

Grissett and Norvell (1992) explored several facets of interpersonal functioning in women with bulimia, including quality of relationships, social skills, and perceived social support. Participants were obtained from an original sample of 600 women screened with the Bulimia Test. Of the 600, 21 could be classified as bulimic. These were then matched by height and weight with 21 women classifying as normal. These groups were then administered the following questionnaires: the Perceived Support Scale, the Quality of Relationships Inventory, the Social Interactions Scale, the Social Competence Questionnaire, and the Symptom Checklist-90-R.

Results indicated significant differences between these two groups of women in several areas. Regarding quality of relationships, women with bulimia reported more frequent negative interactions and lower quality of relationships than did women in the control group. In addition, women with bulimia felt less comfortable in various social situations. This included lower levels of confidence in their abilities to form close relationships, and to seek out social interactions. Finally, women with bulimia perceived less social support than did women in the control group.

Focusing more directly on established romantic relationships, Van Buren and Williamson (1988) studied marital conflict resolution skills as used by women with bulimia. Participants were forty-one marital dyads, in three groups. Twelve couples included one partner seeking treatment of an eating disorder (bulimia). Fourteen couples were seeking marital therapy, and 15 were involved in neither treatment. Partners were administered the Dyadic Adjustment Scale, the Conflict Inventory, and the Relationship Beliefs Inventory.

Results suggested that women with bulimia, and women seeking marital therapy were similarly distressed in their marriages, in contrast to the women in the normal control group. The men seeking marital therapy were most distressed in their marriages, followed by the spouses of women with

bulimia, who were followed in turn by men in the normal control group.

In terms of conflict resolution styles, women with bulimia and women seeking marital therapy were similar with respect to two behaviors: they used problem solving less frequently than did women in the control group; they reported withdrawal from conflict more frequently than did women in the control group. There were no significant differences between the men in the three groups. According to the authors, these results support the notion, reported elsewhere in the literature, that women with bulimia "have disturbances in their interpersonal relationships, particularly in their interactions with members of the opposite sex" (p. 740).

In an effort to obtain a more clear picture of the romantic relationships of women with eating disorders, psychological distress in their husbands was examined (Van den Broucke, Vandereycken & Vertommen, 1994). Three groups of 21 couples each were compared: eating disordered women and their spouses, maritally distressed couples, and nondistressed couples. The authors undertook the study in response to a "predominant clinical impression" in which

> the husbands of anorexic and bulimic patients are often themselves afflicted with serious psychological problems. This is usually considered an indication of the "collusive bond" that allegedly characterizes the relationship between eating-disordered patients and their spouses and

> that is generally attributed to a problematic or pathological partner choice. (p. 270)

The authors argued for the variety of possible alternatives: development of psychological distress in husbands in reaction to the wife's ordeal; changes in a husband's supposed psychological condition that are related to the time of onset of the wife's eating disorder; distress in both partners as a response to marital difficulties. Results indicated an association between marital dissatisfaction and psychological distress for the wives, but not for the husbands. Thus the authors concluded that husbands of women with an eating disorder do not "evidence more complaints of psychological distress" than either maritally distressed or nondistressed husbands (p. 275).

The Self in Sociocultural Context

Another perspective on eating disorders focuses on the self as situated in sociopolitical and historical context. Chernin (1985) interpreted the rising number of eating disorders in the last decades as a manifestation of women's search for the self in the midst of a changing sociopolitical backdrop. Thus Chernin examined women's developmental crisis in relation to the wider world, rather than in terms of intrapsychic factors. Chernin pointed out that the changes effected by the women's liberation movement are partial and gradual when viewed in a broad historical framework; women are suddenly invited to participate in a

male-dominated world in a way that they have not been before:

> We have been seriously harmed during the last millennia and we now must become conscious of the precise forms this harm has taken. The widespread suffering among women today, for which we have no good explanation, no deep and meaningful healing, suggests that we are in grave danger of simplifying the whole question of what it means for a generation of women to take upon their own shoulders this difficult task of entering a world that has refused to see us as human beings with the same crises of development that have received thousands of years of expression on behalf of men. (p. 32)

The wider culture is not a welcoming climate within which female identity development unfolds. Eating disorders are an expression of the uncertainty and confusion that color the individual's painful search for self.

Perlick and Silverstein (1994) refined this vision, and narrated a historical backdrop. They have suggested the existence of a syndrome experienced by women, centered on "ambivalent feelings regarding their gender" (p. 77). The framework is social, the backdrop "massive barriers" impeding women who have endeavored to achieve in the intellectual, professional, and political realms throughout much of history.

In mapping traces of such a syndrome, Perlick and Silverstein began with Greek texts describing a "disease of young women" (Lefkowitz & Fant, 1982; Littre, 1853, cited in Perlick & Silverstein, 1994), that begins "at about the menarche, characterized by amenorrhea, wasting away, great

hunger, vomiting, depression, suicidal ideation, anxiety, aches and pains, and breathing difficulties" (p. 77).

The tracing continues through the 1600s and 1800s, at which time the term "chlorosis" was employed. Symptomatology during these years was not greatly changed: "amenorrhea, appetite disturbance, depression, anxiety, headache, breathing difficulty, and insomnia, as well as disturbed body image" (p. 77). Fear of obesity, overeating followed by vomiting, and the desire for slenderness were also noted. The 19th and early 20th century syndromes of "neurasthenia" and "hysteria" were characterized by features that overlapped substantially with the earlier described Greek "disease of young women" and "chlorosis." The authors pointed out that current specialization of the health fields means the different features of the symptomatology are studied and researched separately. Thus the components of the syndrome have been disconnected from one another.

Perlick and Silverstein renamed this constellation of symptoms "the forgotten syndrome" and contended that it affects women during periods of change regarding female roles. Specifically, they hypothesized that it afflicts women who "strive to achieve in areas traditionally dominated by men and who come to feel limited by being female." The authors documented more subtle fluctuations in prevalence rates during this century. They also explored the biographies of women whose fathers were famous, and

whose mothers were unable to attain academic and professional achievement, and found evidence of the symptomatology of the "forgotten syndrome."

Perlick and Silverstein suggested that at the core of this syndrome is ambivalence about one's own gender. Such ambivalence would result from young women's experience of minimal encouragement to achieve in areas that are highly respected socially, but open only to men; women's witnessing a discrepancy in the types of opportunities open to themselves and their male peers or brothers; their observations of their own mother's perceptions of what it is like to be female; their observations of how their mothers are treated by their fathers and by society. There is a particular tension when doors of opportunity and change appear to be opening, but when gender continues to factor into the equation in a way that is plainly to a woman's disadvantage.

There are those who see in the cultural ideal of thinness, an ideal that represents only 5% of American women in a normal weight distribution (Kilbourne, 1994, p. 398), an outright movement against the female gender (Wolf, 1994). According to this logic, society's exacting and bizarre standards reflect a devaluation of women, mixed with a fear of female power; women's internalization of these standards reflects their desire to be accepted, to be allowed to

exist, to have a self in this society. Wolf (1994) has written:

> But female fat is the subject of public passion, and women feel guilty about female fat, because we implicitly recognize that under the myth our bodies are not our own, but society's, and that thinness is not a private aesthetic, but hunger a social concession exacted by the community. A cultural fixation on female thinness is not an obsession about female beauty, but an obsession about female obedience. .... The nations seize with compulsive attention on this melodrama because women and men understand that it is not about the cholesterol or heart rate or the disruption of a line of tailoring, but about how much social freedom women are going to get away with or concede. (p. 97)

In a world in which women do not define their own place, their own right to act and to exist, the task confronting a young girl is not to figure out what she would like to say, but to decipher what she is supposed to say. Wolf described her perception of the constrictions surrounding womanhood, and her defense of her self:

> Anorexia was the only way I could see to keep the dignity in my body that I had had as a kid, and that I would lose as a woman. It was the only choice that really looked like one: By refusing to put on a woman's body and receive a rating, I chose not to have all my future choices confined to little things, and not to have the choices made for me, on the basis of something meaningless to me, in the larger things. (p. 103)

Paradoxically, conformity to twisted social dictates becomes an effort to rise above the limitations they in fact imply. Thus the triumph and pride in the "mastery" of eating-disordered behaviors so often faced by clinicians.

In conclusion, the evolution of literature unfolds to suggest a multifaceted perspective of the spectrum disordered eating. Among the array of orientations from which this area is approached, prominent themes emerge. There is the perception of a disconnectedness of the inner self (Bruch, 1973, 1978, 1982; Geist, 1989; Sands, 1989, 1991); the prominence of the physical body as a means to representing a lacking inner self structure (Barth, 1989; Casper, 1992; Schupak-Neuberg & Nemeroff, 1993), and alienation from physical and emotional experiencing (Tolman & Debold, 1994). Other themes include women's struggle to negotiate a specific cultural model of adult relationships (Dare & Crowther, 1995; Grissett & Norvell, 1992; Steiner-Adair, 1989, 1990, 1991a, 1991b, 1994; Wurman, 1989), and particular cultural expectations regarding their place in the social structure (Chernin, 1985; Perlick & Silverstein, 1994). A theme that occurs throughout this literature is women's difficult and painful searches for their selves, and for the place of the self in connecting to others.

Hypotheses

(1) Participants in stages of less defined self/identity development will have significantly higher scores on the two measures of disordered eating than will participants in stages of more defined self/identity development.

(2) Scores on a measure of subordination of self in romantic relationships will be significantly and positively correlated with scores on two measures of disordered eating.

CHAPTER 3

METHODS

Participants

A total of 204 female participants were recruited from among several undergraduate psychology classes. They participated voluntarily in in-class sessions during which they filled out a 211-item questionnaire. Men in these classes at the same time participated in an unrelated study of similar length. All participants received extra credit points for their participation. Of the 204 collected questionnaires, 186 were included in this study's analyses. Criteria for inclusion were: responses for all items necessary for a Q-EDD diagnosis, and no more than 20% of all items left blank.

Procedure

Each participant received a questionnaire comprised of the following components: the Extended Objective Measure of Ego Identity Status-2 (EOM-EIS-2, Bennion & Adams, 1986, Appendix B), the Silencing The Self Scale (STSS, Jack, 1991; Jack & Dill, 1992, Appendix E), the Eating Disorders Inventory (EDI, Garner, Olmstead, & Polivy, 1983, Appendix D), and the Questionnaire for Eating Disorder Diagnosis (Q-EDD, Mintz, O'Halloran, Mulholland, & Schneider, 1997,

Appendix C). The inventory sequence was: 1) EOM-EIS-2, STSS, EDI, and Q-EDD. The rationale consisted primarily of a concern to prevent self-consciousness regarding eating-related behaviors to bias subsequent disclosure of self-related information, as the eating-related questionnaires potentially center around sensitive information.

Measures

Disordered Eating. Disordered eating was measured by the Eating Disorders Inventory (Garner, Olmstead, & Polivy, 1983) and the Questionnaire for Eating Disorder Diagnoses (Mintz, O'Halloran, Mulholland, & Schneider, 1997). The Eating Disorders Inventory (EDI, Garner, Olmstead, & Polivy, 1983), assesses "psychological and behavioral traits common in anorexia and bulimia" (p. 15). It consists of eight subscales, including: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interoceptive Awareness, and Maturity Fears. The scale format is self-report, and consists of 64 items with a 6-point Likert scale response ranging from "always" to "never." For each item, the extreme response (keyed as either "always" or "never") earns a 3-point score. The adjacent response earns a 2, the next adjacent response a 1, and the 3 opposite responses earn 0 points. Total scores may span 0 to 192, with higher total scores indicating higher degrees of eating disordered behaviors or beliefs. Example items include: "I get

confused as to whether or not I am hungry," "I have close relationships," and "I wish I were someone else."

Items were originally generated by a group of clinicians who were acquainted with the research literature and who had clinical experience in the area of anorexia nervosa. Items were intended to measure eleven constructs, however, only eight of these met validity and reliability requirements and were then retained as part of the final version of the scale. Items were required to meet two statistical criteria: discrimination between a group of women with anorexia, and a female control group; higher correlation with its own subscale than to any other. In addition, subscales were to have internal consistency coefficients (Cronbach's alpha) above .80 for the sample of women with anorexia. The overall item-total correlation was .63 (SD= 0.13).

Criterion-related validity of the scale was examined through several methods. First, the scale was administered to selected comparison sample groups, including a group of women who met the DSM-III diagnosis of bulimia, a group of women classified as obese, a group of women classified as formerly obese, a group of women recovered from anorexia, and a group of male first and second-year college students. The EDI effectively discriminated between these groups. Criterion-related validity was also supported through agreement between a set of patients' self-reported profiles

and the judgements of experienced clinicians. In addition, the women who had recovered from anorexia scored similarly to a control group of college women.

Support for the construct validity of the EDI was supported through tests of convergent and discriminant validity. Several EDI subscales were correlated with various conceptually related psychological scales, such as the Eating Attitudes Test (Garner & Garfinkel, 1979), the Beck Depression Inventory (Beck, 1978), and several subscales of the Hopkins Symptom Check List (Derogotis, Lipman, Rickels, Uhlenhuth, & Covi, 1974).

Stability of the EDI was examined by administering the scale to a female, non-clinical sample across a one year period. Pearson correlations were calculated for the total score, and for the eight subscale scores. "Considerable stability" was found for all but the following scales: Bulimia, Interoceptive Awareness, and Maturity Fears, for which less stability was found. The authors suggest that lower stability for these subscales might be related to the nature of the constructs they assess, namely "affective and behavioral dimensions" that are more susceptible to fluctuation than the "attitudinal and personality dimensions" measured by the other subscales (p. 99).

The second measure of eating disordered behaviors was the Questionnaire for Eating Disorder Diagnoses (Q-EDD, Mintz, O'Halloran, Mulholland, & Schneider, 1997). The

Q-EDD was developed in order to operationalize the diagnostic criteria of the DSM IV. It can differentiate between individuals with and those without an eating disorder diagnosis; between individuals with a diagnosis of anorexia nervosa and bulimia nervosa; and further, among "eating disordered, symptomatic, and asymptomatic individuals" (Mintz et al., 1997, p. 63).

The Q-EDD contains 50 questions to which the majority of responses are given in a "yes" or "no" format. Responses to the Q-EDD yield frequency data for particular eating disordered behaviors, and also categorical labels (e.g., non-eating disordered, eating disordered). Scoring is conducted according to a series of decision rules described in the scoring manual. This scoring procedure allows for placement of individuals into diagnostic categories, which are as follows: two broader categories are "non-eating disordered" and "eating disordered." The "non-eating disordered" group is comprised of two sub-categories, including "asymptomatic" (no eating disorder-related symptomatology) and "symptomatic" (some symptomatology, but not enough to meet a DSM IV diagnosis). The "eating disordered" group is comprised of six sub-categories, including anorexia, bulimia, and four groups falling into the DSM IV Eating Disorder Not Otherwise Specified Diagnosis: "subthreshold bulimia, menstruating anorexia, nonbingeing bulimia, and binge-eating disorder" (p. 97).

Example items are: "How afraid are you of becoming fat/gaining weight?" and "Does your weight and/or body shape influence how you feel about yourself?"

The Q-EDD was developed as a revision of the Weight Management Questionnaire (WMQ, Mintz & Betz, 1988), based on DSM-III-R criteria, which was itself a revision of another measure based on DSM-III criteria (Ousley, 1986). Old WMQ items were revised and new items were generated in order to conform to changes from the DSM-III-R to the DSM-IV criteria. The content validity of the new items, as well as revisions of the scoring decision rules were examined by experts in the area of eating disorders. The new questionnaire was then administered to a group of ten undergraduate and graduate students who provided further suggestions for revision relating to clarity of items and instructions.

A series of three studies was undertaken to examine the reliability, criterion validity, convergent validity, incremental validity, and interscorer agreement for the Q-EDD. Overall, the results of these studies provide solid support for the validity of this measure in assessing disordered eating. The first study involved a nonclinical sample of women. Convergent validity was assessed via comparison of Q-EDD scores and scores on the BULIT-R (Thelen, Farmer, Wonderlich & Smith, 1991; a test differentiating individuals with bulimia and those without

bulimia), and scores on the EAT (Garner & Garfinkel, 1979; a test that differentiates individuals with anorexia from non-eating disordered individuals). The Q-EDD successfully distinguished between individuals falling into the diagnostic categories as distinguished by the BULIT-R and the EAT.

Criterion validity was examined through comparison of classification by the Q-EDD and by structured clinical interview. An accuracy rate of 98% was found for the Q-EDD's differentiation between eating-disordered and non eating-disordered individuals. An accuracy rate of 90% was found for the Q-EDD's differentiation between eating-disordered, symptomatic, and asymptomatic individuals. Incremental validity was examined in comparison to the BULIT-R. The Q-EDD was found to accurately predict bulimia 78% of the time, whereas the BULIT-R did so only 54% of the time. Interscorer agreement of 100% was found for distinguishing eating-disordered from non eating-disordered, and for distinguishing eating-disordered, symptomatic, and asymptomatic individuals.

In a second study involving another nonclinical sample of women, convergent validity was assessed via comparison of Q-EDD categorization of eating-disordered, symptomatic, and asymptomatic individuals, and scores on the EAT. In this group, EAT scores for the Q-EDD asymptomatic individuals differed significantly from those of the symptomatic and

eating-disordered individuals. However, no significant differences were found between Q-EDD symptomatic and eating-disordered individuals. As in the first study, 100% interscorer agreement was found for distinguishing eating-disordered from non eating-disordered, and for distinguishing eating-disordered, symptomatic, and asymptomatic individuals.

The third study involved a clinical sample, and explored the criterion validity of the Q-EDD through comparison with clinician diagnoses. The Q-EDD's correctly distinguished eating-disordered from non eating-disordered individuals at an accuracy rate of 78%. An accuracy rate of 78% was also supported for the Q-EDD's ability to distinguish eating-disordered, symptomatic, and asymptomatic individuals. A 100% accuracy rate was found for the Q-EDD's differentiation between the categories of anorexia and bulimia.

Self in Relationship. The degree to which self is reflected in a romantic relationship was assessed through the Silencing the Self Scale (STSS, Jack, 1991; Jack & Dill, 1992), which was designed to assess women's beliefs about self in relationship (Jack, 1991, p. 26). The STSS targets the absence, or loss, of self in the context of a romantic relationship. The scale was developed from an interview-based study of women with major depression. The STSS is comprised of 31 statements in a Likert scale format ranging

from 1 (strongly disagree) to 5 (strongly agree). Total scores may range from 31 to 155. Higher scores indicate higher levels of subordination of self in relationships. Example items include "In a close relationship, my responsibility is to make the other person happy" and "In order for my partner to love me, I cannot reveal certain things about myself to him/her."

Originally, 41 items for the STSS were generated, based on the content of interviews with a group of women diagnosed with major depression. These were reviewed for comprehensibility and face validity by a group of nine clinical psychologists. The scale was similarly reviewed for "clarity and comprehensiveness" (Jack & Dill, 1992, p. 100) by two groups of female undergraduates: one group from an introductory psychology class, another group presenting with depression at a university counseling center.

Construct validity, reliability, and internal consistency were examined through a study using three sample groups of women: university students, residents of battered women's shelters, and new mothers who had used drugs during pregnancy. In support of the scale's construct validity, STSS scores were correlated with scores on the Beck Depression Inventory (BDI). Significant correlations between the STSS and the BDI were found within each group, ranging from .50 to .52. Coefficient alphas for each of the

samples were in the range of .86 to .94. A test-retest reliability score of .88 over a two-week period was found.

Self. View of self was assessed through the Extended Objective Measure of Ego Identy Status-2 (EOM-EIS-2, Bennion & Adams, 1986). This instrument is based on Marcia's work in the area of identity development (1966, 1987, 1989), which is in turn grounded by Erikson's theory of psychososical development (1959, 1968). Erikson proposed a series of life stages during which critical "crises," or tasks are to be resolved; the task of adolesence revolves around the maturing of a personal sense of identity. Marcia advanced a classification scheme that would operationalize the status of an individual's identity.

The basis for this status involves the presence or absence of two events or processes: a crisis, questioning, or exploration, and a commitment, or resolution to the crisis. The four identity statuses are: identity achievement, moratorium, foreclosure, and identity diffusion. An identity achieved individual has faced a crisis and resolved it through personal exploration (crisis and commitment). Moratorium implies that the individual is in the midst of the process of exploration (crisis, no commitment). Foreclosure describes individuals who have committed to an identity without having experienced a personal exploration with reference to that commitment (no crisis, commitment). Identity diffusion suggests that the

individual has not engaged in any process of exploration, nor an internally-driven commitment (no crisis, no commitment, Marcia, 1966).

The EOM-EIS-2 is a 64-item scale based on a 6-point Likert scale with points ranging from 1 (strongly agree) to 6 (strongly disagree). It assesses ego-identity status in a total of eight domains, falling into either ideological, or interpersonal categories. The ideological domains include: religion, philosophical lifestyle, occupation, and politics. The interpersonal domains include: friendship, dating, sex-roles, and recreation. There are sixteen test items corresponding to each of the identity statuses. Thus each participant will receive a set of four scores, one for each identity status. Classification of a participant into one particular status category is determined by the highest identity status score.

There is support for strong internal consistency for all eight subscales (Bennion & Adams, 1986). Cronbach alpha coefficients for the ideological domain for achievement, moratorium, foreclosure, and diffusion are as follows: .62, .75, .75, and .62. For the interpersonal domains for achievement, moratorium, foreclosure, and diffusion, they are: .60, .58, .80, and .64.

Construct validity was explored through correlation of EOM-EIS-2 subscales with another assessment measure of identity (Rosenthal, Gurney, & Moore, 1981). EOM-EIS-2

identity achievement subscales were found to correlate positively with the Rosenthal measure of identity. Conversely, the moratorium, diffusion, and foreclosure EOM-EIS-2 subscales were found to correlate negatively with the Rosenthal measure. Foreclosure was positively correlated with authoritarianism; diffusion was negatively correlated with authoritarianism.

In order to establish predictive validity, EOM-EIS-2 identity status was compared to the measures of intimacy and identity on the Rosenthal et al. (1981) measure. Scores for the identity achievement group correlated with higher levels of reported intimacy and identity on the Rosenthal et al. measure. Scores for the diffusion and foreclosure statuses correlated with lower levels of reported intimacy and identity on the Rosenthal et al. measure. Scores for the moratorium status group were associated with scores in the middle to lower ranges on both the levels of intimacy and identity as assessed by the Rosenthal et al. measure.

Analyses

Hypothesis 1, which addresses the relationship between degree of disordered eating and view of self, was to be analyzed by a multivariate analysis of variance in which self development would serve as the independent variable with two levels: the first level was to be composed of the moratorium and diffusion stages; the second level was to be composed of the identity achievement and foreclosure stages.

The dependent variables were to be the EDI and the Q-EDD. It was predicted that participants in the moratorium and diffusion stages would show significantly higher levels of disordered eating than participants in the identity achievement and foreclosure stages.

Hypothesis 2, which addresses the relationship between degree of disordered eating and the place of self in a romantic relationship, was to be assessed using a simultaneous multiple regression in which the EDI and the Q-EDD would serve as predictor variables, and the STSS would serve as the criterion variable. Significantly positive regression coefficients were predicted for the EDI and the Q-EDD.

The nature of the data resulting from participant scores on the Q-EDD made its use inappropriate for assessing the hypotheses, and made the Hypothesis 1 analysis inappropriate as well. The rationale for and details of the analyses that were performed are described in Chapter 4.

CHAPTER 4

RESULTS

Descriptive Statistics

Participants ranged in age from 18 to over 25 years with 10 (5.4%) participants aged 18, 32 (17.2%) participants aged 19, 59 (31.7%) aged 20, 48 (25.8%) aged 21, 19 (10.2%) aged 22, 8 (4.3%) aged 23, 2 (1.1%) aged 24, 1 (.5%) aged 25, and 7 (3.8%) aged over 25 years. Participants were mostly advanced undergraduates, with only 13 (7%) freshmen, 31 (16.7%) sophomores, 79 (42.5%) juniors, 62 (33.3%) seniors, and only 1 (.5%) participant either not in school or employed. The vast majority of participants were White (152, 82.6%). However, there were also 12 (6.5%) who identified themselves as African-American/Black, 12 (6.5%) who identified as Hispanic/Latino/Mexican-American, 5 (2.7%) who identified as Asian American/Pacific Islander, and 3 (1.6%) who identified with a background not represented on the questionnaire.

Participant scores on the EOM-EIS indicated that the majority fell into the foreclosure category (112, 60.2%), and the diffusion category (46, 24.7%). Of the remaining participants, 13 were classified as moratorium (7.0%), and only 1 (.5%) was classified as identity achieved. Fourteen

(7.5%) participants were classified as "unknown." To be classified as "unknown," scores on at least 2 of the participant's four statuses (foreclosure, diffusion, achievement, moratorium) had to be identical.

For ease of understanding, scores on the STSS are presented as total scores divided by the total number of items. Thus overall scores correspond to the scale presented on the original questionnaire. Participant scores on the STSS ranged from .87 to 4.35 on a 1 to 5 point scale. Higher scores represent higher levels of self-silencing. The sample mean was 2.22 (*SD* = .73).

Participants' scores on the EDI ranged from 1.9 to 99.8 on a 0 to 192 point scoring scale, again, with higher scores indicating higher levels of disordered eating. The mean for the sample was 33.9 (*SD* = 22.4). An inspection of the frequency data suggests that although the EDI suffered from a restriction of range, it did not suffer from a floor effect or a pronounced positive skew.

As expected, the vast majority of participants were not diagnosable with an eating disorder. Only 10 (5.4%) participants were diagnosed using the Q-EDD as suffering from either bulimia or anorexia. Another 9 (4.8%) were diagnosed by the Q-EDD as eating disordered NOS (the DSM IV Not Otherwise Specified classification). However, only one person (.5%) was categorized by the Q-EDD as symptomatic. Most of the participants (166, 89.2%) were classified as

non-eating disordered by the Q-EDD. Although the Q-EDD was purported to classify individuals according to a continuum of the specified categories, it failed to do so. For this reason, its inclusion in the proposed analyses of the hypotheses in this study was inappropriate, as will be discussed.

Hypothesis Tests

The first hypothesis predicted that participants in the moratorium and diffusion stages would show significantly higher levels of disordered eating than those in the identity achievement and foreclosure stages. The distribution of the Q-EDD scores is severely positively skewed thus making their inclusion in a MANOVA or any of the related parametric statistics inappropriate. On the other hand, the EDI scores do not show this severe skew, so they can be analyzed using the general linear model approach. MANOVA are appropriate when there are two or more continuous dependent variables. Because only one of the dependent variables has a distribution appropriate for MANOVA, it is now appropriate to analyze that dependent variable (the EDI) using analysis of variance (ANOVA), instead of MANOVA.

A one-way ANOVA was employed to test whether participants in moratorium and diffusion stages did, indeed, have higher levels of disordered eating than those in the identity achievement and foreclosure stages. Results provide clear support for the hypothesis, $F(1, 170) = 5.03$, $p < .03$.

The mean EDI score for moratorium and diffusion participants was .63 (*SD* = .36), whereas the mean EDI score for identity achievement and foreclosure participants was .50 (*SD* = .35).

The second hypothesis predicted that participants with higher levels of disordered eating as assessed by the Q-EDD and the EDI would also demonstrate higher levels of self-silencing as assessed by the STSS.

Again because of the noncontinuous nature of the data from the Q-EDD, the original analysis planned for Hypothesis 2 had to be modified. The Q-EDD was still entered in a simultaneous multiple regression, as originally planned. However, instead of being entered as a continuous variable, it was entered as a dummy coded variable, with two values (not eating disordered and symptomatic vs. eating disordered, including anorexia, bulimia, and NOS categories). Results of this multiple regression indicate that neither Q-EDD nor the interaction of Q-EDD and EDI contributed significantly to the prediction of STSS scores [Q-EDD $F(1, 182) = 0.00$, $p < .97$, Q-EDD X EDI $F(1, 182) = 0.18$, $p < .67$]. On the other hand, these data provide support for Hypothesis 2 because the EDI was a significant predictor of STSS scores and in the predicted direction, $F(1, 182) = 24.90$, $p < .0001$, $r = .35$.

Ancillary Analyses

Not only does the distribution of the Q-EDD preclude parametric testing, the scoring resulted in only a single

participant who was categorized as symptomatic. Thus, the Q-EDD did not provide data to test hypotheses regarding the disordered eating continuum. Nevertheless, the relationship between Q-EDD scores and EOM-EIS scores is interesting in its own right and so was assessed using a chi square analysis, with Q-EDD at two levels (not eating disordered and symptomatic vs. eating disordered, including anorexia, bulimia, and NOS categories). The Q-EDD-diagnosed anorexic, bulimic, and NOS participants were grouped together because so few participants were in any one of these categories that a chi square analysis could not be performed if these groups were analyzed separately. Results of this analysis indicate no significant relationship between Q-EDD and EOM-EIS categories, chi square (1) = .061, $p < .81$.

To assess the degree to which increases in disordered eating as measured by the Q-EDD corresponds to increases in disordered eating as measured by the EDI, a one-way ANOVA was performed with Q-EDD level (asymptomatic vs. NOS vs. anorexia and bulimia) serving as the independent variable and EDI score serving as the dependent variable. The symptomatic Q-EDD category will not be reported because only one participant was in that category. Results of this analysis indicate a correspondence between the Q-EDD and the EDI, $F(3, 182) = 19.51$, $p < .0001$. Post-hoc Tukey HSD analyses with alpha set at $p < .05$ indicate that asymptomatic participants ($M = 0.48$, $SD = 0.31$, $n = 166$)

scored significantly lower on the EDI than either NOS participants (M = 0.85, SD = 0.27, n = 9) or anorexic and bulimic participants (M = 1.09, SD = 0.29, n = 10). No other pairs of means were significantly different from each other.

To assess whether there is a relationship between identity status and self-silencing, a one-way ANOVA was conducted with EOM (achievement and foreclosure vs. diffusion and moratorium) serving as the independent variable and STSS scores serving as the dependent variable. Results indicated that there was indeed a statistically significant relationship between EOM and STSS, $F(1, 170)$ = 4.18, p,.05. Participants with achievement and foreclosure identity statuses (M = 2.17, SD = 0.69) had significantly lower STSS scores than participants in the diffusion and moratorium identity statuses (M = 2.40, SD = .75).

A multiple regression analysis was performed to assess whether the interaction of identity status and self-silencing significantly predicted disordered eating. The EOM and STSS served as predictor variables. The EDI served as the criterion variable. EOM scores were dummy-coded as achievement and foreclosure vs. diffusion and moratorium, consistent with previous hypothesis testing analyses. Results indicated that although both main effects were statistically significant, consistent with other analyses,

the interaction effect was not statistically significant, $F(1, 168,) = 0.06$, $p < .81$.

To assess whether there were racial differences in STSS scores, a one-way ANOVA was conducted with race of participant serving as the independent variable and STSS scores serving as the dependent variable. Only three racial groups were included for analysis (White, African-American and Hispanic American), because fewer than 10 participants indicated membership in the other racial groups. Results indicate that STSS scores did not differ as a function of participant race, $F(2, 173) = 0.92$, $p < .41$. Likewise, analyses of racial differences on the EDI were conducted via a one-way ANOVA and again no statistically significant differences emerged for the three groups, $F(2, 173) = 0.53$, $p < 0.59$. A chi-square analysis was conducted to assess whether race affected identity status membership (EOM: achievement and foreclosure vs. moratorium and diffusion). Results of this analysis indicated that race was not significantly associated with identity status, chi square $(2) = 2.26$, $p < .33$.

In order to explore the void in the symptomatic range suggested by the Q-EDD, frequency data for selected questions on the Q-EDD were generated and are presented here for closer examination.

On the Q-EDD, participants indicated their current weight and their ideal weight. For the purposes of this

analysis, ideal weight was subtracted from current weight in order to calculate a weight discrepancy score. Results demonstrated that the vast majority (82.5%, n = 168) wanted to lose weight. A small group (2.3%) wanted to gain weight, 15.2% were satisfied with their current weight, 40.7% wanted to lose between 1 and 10 lbs, 29.4% wanted to lose between 11 and 20 lbs., and 12.4% wanted to lose between 21 and 75 lbs. Thus 41.8% of participants desired to lose over 10 lbs.

Two Q-EDD questions assessed fear of weight gain. The first question asked "How afraid are you of becoming fat?." Of 183 participants who responded to this question, 9.8% were "not at all afraid"; 54.1% were "a little afraid" or "moderately afraid"; 36.1% were "very much afraid" or "intensely afraid." In sum, 90.2% reported some degree of fear of becoming fat. A similar question, phrased slightly differently, asked "How afraid are you of gaining weight?" Participant responses were consistent with those to the first question. Of 186 respondants, 8.6% indicated that they were "not at all afraid"; 55.9% were "a little afraid" or "moderately afraid"; and 35.5% were "very much afraid" or "intensely afraid." In total, 91.4% expressed some degree of fear of weight gain.

When asked "Does your weight and/or body shape influence how you feel about yourself?", 1.6% responded "not at all"; 53.0% responded "a little" or "a moderate amount";

and 45.4% responded "very much" or "extremely or completely" (n = 185). In other words, a large proportion indicated that weight and/or body shape influenced how they feel about themselves to a substantial degree.

Lastly, the Q-EDD asks participants to indicate whether or not they engage in various behaviors for the purposes of weight control (for example, vomiting, using diuretics). Frequency data were examined for responses to two of the more socially acceptable (or least socially undesirable) types of disordered eating: use of appetite control pills, and strict dieting. Of 182 respondants, 8.8% reported use of appetite control pills. Of 183 respondants, 20.2% reported strict dieting.

Summary

In summary, participants ranged in age from 18 to over 25 years, the majority being 19 or 20 years old. Most were Caucasian in ethnicity, and were not diagnosable with an eating disorder. The majority of participants were categorized as foreclosed in their stage of identity development. The sample averaged in the low to moderate range in terms of self-silencing.

Strong support was found for an association between identity development status and degree of disordered eating, in the predicted direction. That is, participants assessed as being in a more defined stage of self-identity

development had significantly lower levels of disordered eating than did participants assessed as being in more of a state of flux with regard to their self-identity development.

Strong support was also found for an association between self-silencing and degree of disordered eating, in the predicted direction. That is, participants who were assessed as having higher levels of self-silencing beliefs were also assessed as having higher levels of disordered eating.

The Q-EDD and the EDI scores corresponded. A relationship was also found between identity status and self-silencing, with categorization in the more defined identity statuses corresponding to lower levels of self-silencing. No support was found for an interaction between identity and self-silencing on participants' level of disordered eating. In addition, no association was found between race and level of self-silencing, level of disordered eating, or identity status.

A substantial majority of participants wanted to lose weight, indicated fear of weight gain, and reported that their weight and/or body shape influenced how they felt about themselves. Some participants reported use of appetite control pills and strict dieting. These data support the existence of higher levels of disordered eating at the subclinical level than was detected by the Q-EDD.

CHAPTER 5

DISCUSSION

Previous research and writing in the area of disordered eating has suggested that an impoverished self-structure, or sense of self in the wider social culture, is related to the constellation of experience of eating disorders. Against the background of this body of literature, this study evaluated the idea that an unarticulated or muffled sense of self, experienced either individually or in the context of a romantic relationship, leaves a woman more vulnerable to psychological distress in the form of disordered eating. This chapter will provide a summary and interpretation of the results of the study, its limitations, and implications for future research and practice.

Summary and Interpretation of the Results

As has been noted, the Q-EDD failed to function as a measure of disordered eating as a continuous variable. Therefore, its inclusion in the tests of the hypotheses in this study was inappropriate. The only fair tests of the hypotheses were those involving the EDI as a measure of disordered eating because the hypotheses make predictions about the full continuum of disordered eating.

The Q-EDD does capture the diagnosable ranges of disordered eating, as it translates precisely the DSM-IV criteria for anorexia, bulimia, and the NOS (Not Otherwise Specified) categories. However, the Q-EDD criteria for the "symptomatic" category apparently do not accurately capture the range they are hypothesized to target. Again, the symptomatic category is situated between the NOS and asymptomatic (healthy) ranges, and thus may be supposed to include a wide range of subclinical symptoms of disordered eating. However, the Q-EDD criteria for categorization as symptomatic are quite narrow. For example, in order to be classified as symptomatic, a woman must at the least be of low weight or severe underweight (classified by a body mass index) and be very afraid of weight gain and have missed at least 3 consecutive menstrual cycles. These criteria alone exclude an entire group of women who could exhibit subthreshold symptomatology related to the bulimia constellation of behaviors, rather than the anorexia constellation. In consequence, the Q-EDD classifies women with subthreshold bulimic symptoms as asymptomatic, or healthy.

The Q-EDD also does not systematically identify participants experiencing elements of disordered eating such as intense fear of weight gain. Information revealed in the ancillary analyses support this conclusion. For instance, 82.5% of respondants wanted to lose weight, 45.5% reported

that their weight and/or body shape influenced how they feel about themselves very much or extremely, and 91.4% expressed some degree of fear of weight gain. While these responses in isolation are not sufficient for a clinical diagnosis, they do merit attention in that they do constitute aspects of disordered eating. It is worth noting that the proportion of participants responding to these questions in a manner consistent with disordered eating is very high. If this proportion is compared to the high percentage diagnosed as asymptomatic by the Q-EDD (89.2%), it becomes apparent that a range of subclinical symptomatology is not at all identified by the Q-EDD. Thus, the Q-EDD functioned as a binary measure, in contrast to the EDI, which did identify a continuous spectrum of disordered eating. For this reason, analyses using the Q-EDD are ancillary to the main hypothesis-testing analyses.

Hypothesis 1 addressed the relationship between identity development and degree of disordered eating. Specifically, it was predicted that participants classified by the EOM-EIS in the moratorium and diffusion statuses (characterized by a state of flux) stages would have higher levels of disordered eating than participants in the identity achievement and foreclosure statuses (which are more well-defined, settled stages of identity development). A significant relationship was found between EOM-EIS categories and the EDI scores, providing clear support for

Hypothesis 1. Participants classified in the diffusion and moratorium statuses had higher levels of disordered eating than did participants in the achievement and foreclosure statuses. This finding is consistent with literature emphasizing the connection between sense of self and disordered eating (e.g., Barth, 1989; Bruch, 1962, 1973, 1978; Dare & Crowther, 1995; Geist, 1989; Sands, 1989, 1991).

Hypothesis 2 addressed the relationship between degree of disordered eating and self-silencing in a romantic relationship. Specifically, Hypothesis 2 predicted that participants reporting higher levels of self-silencing in a romantic relationship would demonstrate higher levels of disordered eating as assessed by the Q-EDD and the EDI. A significant positive relationship between the STSS and the EDI was found, demonstrating strong support for the idea that higher self-silencing is associated with higher levels of disordered eating. This finding is consistent with literature stressing the connection between women's experience of the female gender role in Western societies and disordered eating (e.g., Steiner-Adair, 1989, 1991a, 1991b; Perlick & Silverstein, 1994).

As expected, no relationship was found between the Q-EDD and the EOM-EIS, nor between the Q-EDD and the STSS. Given the patterns emerging from results involving the two measures of disordered eating, the relationship between the

two (the Q-EDD and the EDI) was explored. Results were consistent with emerging beliefs regarding the function of the two inventories. A significant difference in EDI score was found only between one pair of groups: Q-EDD asymptomatic participants and Q-EDD eating disorder-diagnosed participants.

The relationship between identity status and self-silencing was explored. Participants who were classified in more well-defined identity statuses had lower levels of self-silencing than did participants classified in less well-defined identity statuses. This finding suggests that there is an association between having a more defined sense of self and a tendency to believe that one has a right to voice that self in the context of a romantic relationship. This finding is consonant with literature emphasizing the connection between possession of a grounded sense of self and of a sense of the right to voice or express that self in various social contexts (e.g., Steiner-Adair, 1989, 1991a, 1991b).

Whether or not the interaction of self-silencing and identity status constituted a uniquely powerful predictor of disordered eating was also investigated. No suppport was found for this notion. In other words, whereas clear support was found for an association between identity status and disordered eating, as well as between self-silencing and disordered eating, no support was found for an association

between the interaction of self-silencing and identity status in the prediction of disordered eating.

Limitations of the Study

A first limitation of this study relates to the nature of the sample. Although the college population was a target of the study, the results are limited by several defining features of this college sample: a southern geographic location, a primarily Caucasian ethnicity, and a socioeconomic background that probably ranges between the middle and upper classes.

A second limitation relates to the sensitivity of the information requested by the questionnaire, especially the information related to disordered-eating behaviors. Many of these behaviors are not considered socially desirable (i.e., vomiting, use of laxatives) and participants may have been reluctant to disclose information pertaining to such behaviors, even though the questionnaire was completely anonymous.

A third limitation to this study is the presence of mono-operation bias with regard to assessment of disordered eating. As a result of the failure of the Q-EDD to measure the continuum of disordered eating, that is, the failure to identify symptomatology in the subclinical range, the EDI was the only measure that could be appropriately used in the analyses.

Fourth, this study does not address the issue of causality. A wealth of theory generated by clinicians and researchers is consistent with the conceptualization advanced in this study, that an unsettled sense of self as well as silencing the self in romantic relationships can contribute to disordered eating. However, the data generated in this study do not provide evidence confirming the causal nature of these hypotheses. For example, these data do not exclude the possibility that disordered eating leads to self-silencing and/or flux in one's sense of self.

Nor do these data rule out the possibility that some third variable is influencing all of those operationalized in this study. For instance, an association between negative affect and self-silencing has been demonstrated (Drew & Heesacker, 1997), as has an association between negative affect and negative view of self (Beck, 1972). It cannot be ruled out that negative affect is the factor driving all the associations involving the variables in question in this study.

Implications for Future Research

The results of this study offer support for the existence of self-related patterns of experience associated with a portion of the continuum of disordered eating below the clinical range. The EDI appeared to capture information related to that subclinical range. In contrast, the Q-EDD provided information about the diagnosable range of eating

disordered behavior, but did not address the subclinical range. Future refinement of the Q-EDD aimed toward more effectively measuring the continuum of disordered eating, or more specifically, altering the criteria for the symptomatic category, might provide valuable information regarding subclinical levels of eating disordered behavior, situated in relation to the diagnosable levels.

Future research might also explore in more detail the nature of a spectrum of disordered eating experience. For instance, is level of disordered eating in a given population more normally distributed? Or do distinct constellations of experience tend to cluster in consistent patterns, thus characterizing a skewed, or otherwise non-normal distribution? In other words, do people tend to experience disordered eating only to specific degrees, with intermediate levels being fairly uncommon?

Future research with other college-age samples might examine patterns related to distinct geographical and ethnic/racial features of the students in those areas. Analyses for race-related differences in this study revealed no differences among Caucasian, African-American, and Hispanic/Latino/Mexican-American participant groups. However, future research could explore these groups with larger sample sizes. Also, future research might examine the experiences of groups either not represented, or not represented in sufficient numbers in this sample for

analyses to be conducted, such as Asian American/Pacific Islander, American Indian, and mixed-race groups. In addition, future research extending the upper and lower limits of participants' age could expand understanding of the temporal framework for the developmental tasks relating to self, self-in-relationship, and disordered eating experience.

Finally, future experimental research might explore the causal aspects of the issues addressed in this study. Similarly, experimental research could examine the relationships between identity, self-silencing and other forms of dysfunctional behavior, such has those traditionally referred to as neurotic behaviors.

Implications for Practice

The findings from this study should also be considered for their implications for the therapeutic context. An association between flux in identity development and increased levels of disordered eating suggests the potential usefulness of a self-identity development framework in psychotherapy with college-aged women who are dealing with eating-related issues. These results constitute support for the idea articulated in the psychotherapy literature that attending to the processes of refining self-identity, which are normal to the developmental period of the college years, can be an important part of addressing eating-related difficulties (Barth, 1989; Steiner-Adair, 1989, 1991a,

1991b; Wurman, 1989). Within this framework, a psychotherapist might focus particularly on facilitating a client's awareness and expression of her sense of herself as an individual, as separate from, and connected to others.

The association between self-silencing in romantic relationships and increased levels of disordered eating may enrich clincians' understanding of women's psychosocial experience of which disordered eating is a part. This association is consistent with a conceptualization of disordered eating that encompasses the concept of gender, and the meaning that gender infuses into relationships, the social structure, and the experience of the self in the wider world (Brown, 1985, 1989; Chernin, 1985; Perlick & Silverstein, 1994; Steiner-Adair, 1991; Tolman & Debold, 1994; Wolf, 1994). This perspective views disordered eating as a social issue that affects women in a particular way, rather than a women's issue with social underpinnings. In other words, it is perhaps more helpful to understand disordered eating as an individual's experience inextricably related to the broader social context and encompassing relationships between men and women, rather than as the experience of individual women, against a more distant social backdrop.

Within the context of psychotherapy, the findings in this study suggest several avenues worthy of consideration. Literature in the area of eating disorders has emphasized

the importance of relationships (e.g., Grissett & Norvell, 1992; Steiner-Adair, 1989, 1991a, 1991b; Thelen, Farmer, McLaughlin Mann, & Pruitt, 1990; Tolman & Debold, 1994). Specifically, psychotherapists may wish to attend to a woman's self-related beliefs regarding her role in romantic relationships. Extending this idea, it might be helpful to examine the extent to which a woman accurately perceives the gender-related limits and freedoms that characterize her culture. This type of discussion might facilitate an awareness of the ways in which her experience of disordered eating may be a response to social and cultural demands, many in the form of internalized beliefs regarding her inner sense of self as well as relationship-related beliefs.

On a broader level, these findings also lend support to a conceptualization of disordered eating as a continuum in which understanding of the entire spectrum enhances understanding of experiences at different levels of that spectrum, including both diagnosable and the non-diagnosable levels. This conceptualization contrasts with a view of dysfunctional behavior in which clinically diagnosable disorder is isolated from the rest of the spectrum, and in which the subclinical, or non-diagnosable ranges are assumed to be monolithic, and relatively uninformative regarding the diagnosable disorders.

The most widely used conceptualization of disordered eating tends to isolate severe symptomatology from more

normal psychological and social processes. The viewpoint is binary, with clinically diagnosable experiences held in opposition to normal functioning. Indeed, psychology only articulates names for diagnosable constellations: anorexia, bulimia, and the developing "binge-eating disorder," for example. This perspective shapes the type of information researchers and clinicians obtain about the more severe areas of disorder. However, when the broader picture is lost, information is obscured that could inform understanding, not only of the subclinical range, but of the clinically diagnosable range as well. A move toward a continuum-based perspective creates the potential for a shift: from viewing the eating disorders as a baffling constellation of symptoms, to viewing disordered eating as a broad spectrum of experience extending from a common and thus more understandable response to life.

In conclusion, as young women face the developmental tasks of knowing who they are, how they will relate to others, and how they will find a place in this world, their struggles with disordered eating continue to appear mysterious to many around them. A perspective that situates the experience of these women within a larger context--with respect to relationships and social structure, and with respect to the broader continuum of disordered eating--may help to dispel the mystery.

APPENDIX A
INFORMED CONSENT FORM

My name is Romy Cawood. I am a doctoral student in Counseling Psychology and am studying people's view of self. If you decide to participate, you will complete a series of questionnaires. I am very interested in your ideas and hope that you will answer thoughtfully. Possible benefits might include an increased awareness of your own thoughts and beliefs. I foresee no risks.

Your participation in this project is completely voluntary. Your grade will not be affected should you decide not to participate. In exchange for your participation you will receive extra credit points equivalent to approximately 2-3 points out of a total of 150-300, according to the preferences and course design of your particular instructor.

If you so choose, you may stop at any point during completion of these questionnaires. You do not have to answer any question you do not wish to answer. Your comments will be anonymous. It might take you 45-60 minutes to complete the questionnaires.

If you have any questions about the procedure, you are welcome to bring them to me. Messages can be left for me at 114 Psychology Building, University of Florida, Gainesville, Florida, 32611.

APPENDIX B

EXTENDED OBJECTIVE MEASURE OF EGO-IDENTITY STATUS-2

Read each item and indicate to what degree it reflects your own thoughts and feelings. If a statement has more than one part, please indicate your reaction to the item as a whole.

1 = Strongly Agree
2 = Moderately Agree
3 = Agree
4 = Disagree
5 = Moderately Disagree
6 = Strongly Disagree

1. I haven't chosen the occupation I really want to get into, and I'm just working at what is available until something better comes along.

2. When it comes to religion I just haven't found anything that appeals and I don't really feel the need to look.

3. My ideas about men's and women's roles are identical to my parents'. What has worked for them will obviously work for me.

4. There's no single "life style" which appeals to me more than another.

5. There are a lot of different kinds of people. I'm still exploring the many possibilities to find the right kind of friends for me.

6. I sometimes join in recreational activities when asked, but I rarely try anything on my own.

7. I haven't really thought about a "dating style." I'm not too concerned whether I date or not.

8. Politics is something that I can never be too sure about because things change so fast. But I do think it's important to know what I can politically stand for and believe in.

9. I'm still trying to decide how capable I am as a person and what jobs will be right for me.

10. I don't give religion much thought and it doesn't bother me one way or the other.

11. There's so many ways to divide responsibilities in marriage, I'm trying to decide what will work for me.

12. I'm looking for an acceptable perspective for my own "life style" view, but haven't really found it yet.

13. There are many reasons for friendship, but I choose my close friends on the basis of certain values and similarities that I've personally decided on.

14. While I don't have one recreational activity I'm really committed to, I'm experiencing numerous leisure outlets to identify one I can truly enjoy.

15. Based on past experiences, I've chosen the type of dating relationship I want now.

16. I haven't really considered politics. It just doesn't excite me much.

17. I might have thought about a lot of different jobs, but there's never really been any question since my parents said what they wanted.

18. A person's faith is unique to each individual. I've considered and reconsidered it myself and know what I can believe.

19. I've never really seriously considered men's and women's roles in marriage. It just doesn't seem to concern me.

20. After considerable thought I've developed my own individual viewpoint of what is for me an ideal "lifestyle" and don't believe anyone will be likely to change my perspective.

21. My parents know what's best for me in terms of how to choose my friends.

22. I've chosen one or more recreational activities to engage in regularly from lots of things and satisfied with those choices.

23. I don't think about dating much. I just kind of take it as it comes.

24. I guess I'm pretty much like my folks when it comes to politics. I follow what they do in terms of voting and such.

25. I'm not really interested in finding the right job, any job will do. I just seem to flow with what is available.

26. I'm not sure what religion means to me. I'd like to make up my mind but I'm not done looking yet.

27. My ideas about men's and women's roles have come right from my parents and family. I haven't seen any need to look further.

28. My own views on a desirable lifestyle were taught to me by my parents and I don't see any need to question what they taught me.

29. I don't have any real close friends, and I don't think I'm looking for one right now.

30. Sometimes I join in leisure activities, but I really don't see a need to look for a particular activity to do regularly.

31. I'm trying out different types of dating relationships. I just haven't decided what is best for me.

32. There are so many political parties and ideals. I can't decide which to follow until I figure it all out.

33. It took me awhile to figure it out, but now I really know what I want for a career.

34. Religion is confusing to me right now. I keep changing my views on what is right and wrong for me.

35. I've spent some time thinking about men's and women's roles in marriage and I've decided what will work best for me.

36. In finding an acceptable viewpoint to life itself, I find myself engaging in a lot of discussions with others and some self exploration.

37. I only pick friends my parents would approve of.

38. I've always liked doing the same recreational activities my parents do and haven't ever seriously considered anything else.

39. I only go out with the type of people my parents expect me to date.

40. I've thought my political beliefs through and realize I can agree with some and not other aspects of what my parents believe.

41. My parents decided a long time ago what I should go into for employment and I'm following through their plans.

42. I've gone through a period of serious questions about faith and can now say I understand what I believe in as an individual.

43. I've been thinking about the roles that husbands and wives play a lot these days, and I'm trying to make a final decision.

44. My parents views on life are good enough for me, I don't need anything else.

45. I've had many different friendships and now I have a clear idea of what I look for in a friend.

46. After trying a lot of different recreational activities I've found one or more I really enjoy doing by myself or with friends.

47. My preferences about dating are still in the process of developing. I haven't' fully decided yet.

48. I'm not sure about my political beliefs, but I'm trying to figure out what I can truly believe in.

49. It took me a long time to decide but now I know for sure what direction to move in for a career.

50. I attend the same church as my family has always attended. I've never really questioned why.

51. There are many ways that married couples can divide up family responsibilities. I've thought about lots of ways, and now I know exactly how I want it to happen for me.

52. I guess I just kind of enjoy life in general, and I don't see myself living by any particular viewpoint to life.

53. I don't have any close friends. I just like to hang around with the crowd.

54. I've been experiencing a variety of recreational activities in hopes of finding one or more I can really enjoy for some time to come.

55. I've dated different types of people and know exactly what my own "unwritten rules" for dating are and who I will date.

56. I really have never been involved in politics enough to have made a firm stand one way or the other.

57. I just can't decide what to do for an occupation. There are so many that have possibilities.

58. I've never really questioned my religion. If it's right for my parents it must be right for me.

59. Opinions on men's and women's roles seem so varied that I don't think much about it.

60. After a lot of self-examination I have established a very definite view on what my own life style will be.

61. I really don't know what kind of friend is best for me. I'm trying to figure out what friendship means to me.

62. All of my recreational preferences I got from my parents and I haven't really tried anything else.

63. I date only people my parents would approve of.

64. My folks have always had their own political and moral beliefs about issues like abortion and mercy killing and I've always gone along accepting what they have.

The test construction manual can be obtained from Dr. Gerald R. Adams, Department of Family Studies, University of Guelph, Guelph, Ontario, Canada N1G 2W1. Send a written request and a $25 US money order to that address or order through gadams@uoguelph.ca

APPENDIX C
QUESTIONNAIRE FOR EATING DISORDER DIAGNOSIS

Please complete the following questions as honestly as possible.

Sex (please circle) Male Female

Age: _____

School/Occupational Status: (Please circle)
College Freshman
College Sophomore
College Junior
College Senior
Not in School/Employed
(specify:_____)

Race/Ethnicity: (Please circle)
Caucasian/White
African-American/Black
Hispanic/Latino/Mexican-American
American Indian
Asian American/Pacific Islander
Other:_____
(specify)

Present height: _____ feet _____ inches
Present weight: _____ pounds

My body frame is: (please circle) small medium large

I would like to weigh _____ pounds

1. Do you experience recurrent episodes of binge eating, meaning eating in a discrete period of time (e.g., within any 2-hour period) an amount of food that is definitely larger than most people would eat during a similar time period?

YES NO

If YES: Continue to answer the following questions.

If NO: Skip to Question #4

2. Do you have a sense of lack of control during the binge eating episodes (i.e., the feeling that you cannot stop eating or control what or how much you are eating?)

YES NO

3. Circle the answers within the two sets of parentheses below that best fit for you:

On the average, I have had (1, 2, 3, 4, 5, 6 or more) binge eating episodes a WEEK for at least (1 month, 2 months, 3 months, 4 months, 5 months, 6-12 months, more than one year)

4. Please circle the appropriate responses below concerning things you may do to prevent weight gain. If you circle yes to any question, please indicate how often on the average you do this and how long you have been doing this.

a) Do you make yourself vomit? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

b) Do you take laxatives? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

c) Do you take diuretics (water pills?) YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

d) Do you fast (skip food for 24 hours?) YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

e) Do you chew food but spit it out? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

f) Do you give yourself an enema? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

g) Do you take appetite control pills? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

h) Do you diet strictly? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

i) Do you exercise a lot? YES NO
How often do you do this?
Daily Twice/Week Once/Week Once/Month

How long have you been doing this?
1 month 2 months 3 months 4 months 5-11 months
More than a year

5. If you answered YES to "exercise a lot," please answer questions #5a, 5b, and 5c on the next page. If you answered NO to "exercise a lot," skip to question #6.

5a. Fill in the blanks below:

I _____ (types of exercise, e.g., jog, swim)
for an average of _____ hours at a time.

5b. My exercise sometimes significantly interferes with important activities.

YES NO

5c. I exercise despite injury and/or medical complications.

YES NO

For the following questions, circle the response that best reflects your answer:

6. Does your weight and/or body shape influence how you feel about yourself?

1	2	3	4	5
Not at all	A Little	A Moderate Amount	Very Much	Extremely or Completely

7. How afraid are you of becoming fat?

1	2	3	4	5
Not at all Afraid	A Little Afraid	Moderately Afraid	Very Much Afraid	Intensely Afraid

8. How afraid are you of gaining weight?

1	2	3	4	5
Not at all Afraid	A Little Afraid	Moderately Afraid	Very Much Afraid	Intensely Afraid

9. Do you consider yourself to be:

1	2	3	4	5	6
Grossly Obese	Moderately Obese	Overweight	Normal Weight	Low Weight	Severely Underweight

10. Certain parts of my body (e.g., my abdomen, buttocks, thighs) are too fat.

YES NO

11. I feel fat all over.

YES NO

12. I believe that how little I weigh is a serious problem.

YES NO

13. I have missed at least 3 consecutive menstrual cycles (not including those missed during a pregnancy).

YES NO

APPENDIX D
EATING DISORDERS INVENTORY

Always	Usually	Often	Sometimes	Rarely	Never
1	2	3	4	5	6

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty about overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.
27. I feel inadequate.
28. I have gone on eating binges where I have felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.

35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.
38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a small meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close)
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.
61. I eat or drink in secrecy.
62. I think that my hips are just the right size.
63. I have extremely high goals.
64. When I am upset, I worry that I will start eating.

APPENDIX E
SILENCING THE SELF SCALE

Please circle the number that best describes how you feel about each of the statements listed below.

Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
1	2	3	4	5

1. I think it is best to put myself first because no one else will look out for me.

2. I don't speak my feelings in an intimate relationship when I know they will cause disagreement.

3. Caring means putting the other person's needs in front of my own.

4. Considering my needs to be as important as those of the people I love is selfish.

5. I find it harder to be myself when I am in a close relationship than when I am on my own.

6. I tend to judge myself by how I think other people see me.

7. I feel dissatisfied with myself because I should be able to do all the things people are supposed to be able to do these days.

8. When my partner's needs and feelings conflict with my own, I always state mine clearly.

9. In a close relationship, my responsibility is to make the other person happy.

10. Caring means choosing to do what the other person wants, even when I want to do something different.

11. In order to feel good about myself, I need to feel independent and self-sufficient.

12. One of the worst things I can do is to be selfish.

13. I feel I have to act in a certain way to please my partner.

14. Instead of risking confrontations in close relationships, I would rather not rock the boat.

15. I speak my feelings with my partner, even when it leads to problems or disagreements.

16. Often I look happy enough on the outside, but inwardly I feel angry and rebellious.

17. In order for my partner to love me, I cannot reveal certain things about myself to him/her.

18. When my partner's needs or opinions conflict with mine, rather than asserting my own point of view I usually end up agreeing with him/her.

19. When I am in a close relationship I lose my sense of who I am.

20. When it looks as though certain of my needs can't be met in a relationship, I usually realize that they weren't very important anyway.

21. My partner loves and appreciates me for who I am.

22. Doing things just for myself is selfish.

23. When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions.

24. I rarely express my anger at those close to me.

25. I feel that my partner does not know my real self.

26. I think it's better to keep my feelings to myself when they do conflict with my partner's.

27. I often feel responsible for other people's feelings.

28. I find it hard to know what I think and feel because I spend a lot of time thinking about how other people are feeling.

29. In a close relationship I don't usually care what we do, as long as the other person is happy.

30. I try to bury my feelings when I think they will cause trouble in my close relationships.

31. I never seem to measure up to the standards I set for myself.

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BIOGRAPHICAL SKETCH

Romy Lanier Cawood grew up in Yellow Springs, Ohio. Her father is the editorial page editor of the Dayton Daily News. Her mother has worked as an instructor in Spanish at Wright State University, the University of Dayton, and Wittenberg University, and currently works as a legal assistant to an attorney. Romy graduated from Yellow Springs High School in 1985.

Romy received a Bachelor of Arts degree in French from Davidson College in 1989, and a Master of Arts degree in French from Middlebury College in 1991. She began study in psychology at the Ohio State University and then went on to receive a Master of Science degree in counseling psychology from the Unviversity of Kentucky in 1994.

Romy entered the counseling psychology program at the University of Florida in 1994. She is scheduled to complete her Ph.D. in 1998.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Martin Heesacker, Chairman
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Franz Epting
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

James I. Morgan
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Lisa Marie Brown
Assistant Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Silvia Rafuls
Assistant Professor of Counselor Education

This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Dean, Graduate School